SEALED

Receipt # D5082835

CLERK US DISTRICT COURT
NORTHERN DIST. OF TX
FILED

2015 JUN 19 PM 12:58

NOTICE: THIS DOCUMENT CONTAINS SENSITIVE DATA. *See* LR 79.3

ORIGINAL

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

DEPUTY CLERK RAN

PARTY UNDER SEAL,	§	
	§	
Relator,	§	**Case No.** 3-15CV-2085L
	§	
VS.	§	
	§	
PARTIES UNDER SEAL,	§	
	§	
Defendants	§	

RELATOR'S ORIGINAL COMPLAINT (UNDER SEAL)

Respectfully submitted,

WITT, McGREGOR & BOURLAND, P.L.L.C.

By: /s/ Matthew C. Witt
MATTHEW C. WITT
State Bar No. 21831780

8004 Woodway Drive, Suite 400
Waco, Texas 76712
(254) 751-9133
(254) 751-9134 *fax*
mattwitt@wmbwaco.com

ATTORNEYS FOR RELATOR

NOTICE: THIS DOCUMENT CONTAINS SENSITIVE DATA. *See* LR 79.3

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

PARTY UNDER SEAL,	§	
	§	
Relator,	§	
	§	**Case No.** _____
VS.	§	
	§	
PARTIES UNDER SEAL,	§	
	§	
Defendants	§	

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Waco, Texas 76712
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mattwitt@wmbwaco.com

ATTORNEYS FOR PLAINTIFF
THE STATE OF TEXAS
ex rel. CLINT ANDERSON

82835

NOTICE: THIS DOCUMENT CONTAINS SENSITIVE DATA. *See* LR 79.3

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

PARTY UNDER SEAL,	§	
	§	
Relator,	§	
	§	**Case No.** _____
VS.	§	
	§	
PARTIES UNDER SEAL,	§	
	§	
Defendants	§	

RELATOR'S ORIGINAL COMPLAINT (UNDER SEAL)

TO THE HONORABLE JUDGE OF SAID COURT:

Relator, Clint Anderson, files this Original Petition under seal, bringing this action based on his direct, independent, and personal knowledge and also on information and belief. Relator brings this action against Defendants for violations of Section 3729, Title 31 of the United States Code, for the United States Government (the "Government") and for himself, pursuant to the authority granted by Section 3730(b), Title 31 of the United States Code, and would show unto the Honorable Court as follows:

I.

DISCOVERY CONTROL PLAN

1. This case is filed *in camera* and under seal pursuant to Section 3730(b)(2), Title 31 of the United States Code and Local Rule 79.3. Upon unsealing, discovery is intended to be conducted under Section 3731-3733, Title 31 of the United States Code.

II.

PARTIES AND SERVICE

2.1. The Plaintiff, **Clint Anderson** ("Relator") is an individual residing in Killeen, Bell County, Texas. From May 2012 to August 2012, Relator was employed as a therapist at Ellis County Community Services, Inc., in Ellis County, Texas.

2.2. The last three digits of Plaintiff's social security number are 395.

2.3. Relator is an original source of the information underlying this Petition and the Disclosure Statement served with Relator's Original Petition. Relator has also previously provided this information to the United States Government prior to filing this Petition. Relator has independent knowledge of the information on which the allegations are based. Relator brings this action on behalf of the United States Government and himself against Defendants for treble damages and civil penalties arising from the Defendants' misrepresentations and failure to disclose material evidence, false statements, and false claims in violation of the False Claims Act, Section 3729, Title 31of the United States Code.

2.4. Defendant Alexis Norman is an individual whose principal place of business is located at 307 North Grand Avenue, Waxahachie, Texas, 75165. Service of said Defendant as described above may be effected by personal delivery at the above address or wherever she may be found.

2.5. Defendant Greater Southwest Group Corp. is a corporation with its principal office located at 625 Jealouse Way, Suite 116, Cedar Hill, Texas 75104-2578. Said Defendant may be served with process by serving its registered agent, Carlette Roberts, 625 Jealouse Way, Cedar Hill, Texas 75104. Service of said Defendant as described above may be effected by personal delivery.

2.6. Defendant Ellis County Community Services, Inc. is a corporation with its principal office located at 307 North Grand Avenue, Waxahachie, Texas 75165. Said Defendant may be

served with process by serving its registered agent, Alexis Norman, 307 North Grand Avenue, Waxahachie, Texas 75165. Service of said Defendant as described above may be effected by personal delivery.

III.

JURISDICTION

3.1. The Court has jurisdiction because it is a judicial district in which the defendants can be found, reside, transact business, and which the acts at issue occurred, pursuant to Section 3732(a), Title 31 of the United States Code.

IV.

FILING UNDER SEAL

4.1. In accordance with Section 3730(b)(2), Title 31 of the United States Code and Local Rule 79.3, this Original Complaint is filed *in camera* and under seal and will not be served on the Defendants until the Court so orders.

4.2. In accordance with Section 3730(b)(2), Title 31 of United States Code, a copy of this Original Complaint and written disclosure has been served on the Government pursuant to Rule 4(d)(4) of the Federal Rules of Civil Procedure.

V.

FACTUAL BACKGROUND

5.1. On or about July 28, 2012, Relator had a conversation with an employee of Defendant Ellis County Community Services, Inc. ("Ellis") or Defendant Greater Southwest Group Corporation ("Greater Southwest"), Rosalba Fernandez. Ms. Fernandez mentioned that as part of her duties, she entered billing information into Ellis' software system. When Relator asked

Ms. Fernandez what type of billing she was doing, Ms. Fernandez told Relator she was doing Medicaid billing.

5.2. Relator recalled a conversation between himself and Defendant Alexis Norman, owner of Ellis ("Norman"), wherein Norman informed Relator that Ellis is a grant-funded Medicaid provider, but it does not perform Medicaid billing.

5.3. When Relator further inquired into Ms. Fernandez's billing work, Ms. Fernandez stated that she billed Medicaid often, at the direction of Norman. Ms. Fernandez told Relator that Norman gave Ms. Fernandez two large notebooks filled with client names and billing information that she entered into their software system to bill Medicaid.

5.4. Ms. Fernandez told Relator that she did not know what services she was billing Medicaid for, because Norman gave her a form that had the codes she needed to enter. Ms. Fernandez further told Relator that she was the individual that entered all of the client information into the company's software system, and she got all of the client information out of the two large notebooks Ms. Fernandez received from Norman.

5.5. Ms. Fernandez agreed to provide Relator with a copy of the billing information she told him about. Ms. Fernandez provided Relator with a copy of instructions on completing the billing forms, and a copy of a Health Insurance Claim Form ("HICF") for a client, attached hereto as Exhibits "1" and "2," respectively.

5.6. On examining the forms, Relator saw that the HICF for the client on Exhibit 2 showed Medicaid was billed for 2 hours a day for 5 consecutive days for services provided at Ellis' Grand Avenue location ("Grand Avenue"). However, the client's address was in a city approximately 6.5 hours from the Grand Avenue location. Relator asked Ms. Criner, the program

manager at Grand Avenue, if she knew the client. Ms. Criner told Relator she had never met or seen the client's name listed on billing.

5.7. When Relator further investigated Exhibit 2, he discovered that his NPI (National Provider Identifier) number had been used on this client's HICF to bill Medicaid. However, Relator was not working at Grand Avenue on the dates listed on the HICF. Therefore, he contacted the only provider working at Grand Avenue on the dates listed on the HICF, Mr. Van Zandt, to determine if the client was Mr. Van Zandt's patient. Mr. Van Zandt stated that he did not know the client listed on the HICF, and he was on vacation during the dates listed on the HICF.

5.8. On July 30, 2012, Relator asked Ms. Criner for the attendance log for Grand Avenue for the dates listed on the HICF in Exhibit 2, which Ms. Criner provided for him. The client on the HICF was not listed on the Grand Avenue attendance log. Ms. Criner again told Relator she did not know the client whose name appeared on the HICF.

5.9. On or about August 3, 2012, Ms. Fernandez provided Relator with a folder containing HICF sheets for approximately 17 other clients for services allegedly provided by Ellis at the Grand Avenue location. These items are attached hereto as Exhibits 3-19. On several of the HICF sheets, Relator's NPI number was used for services that were allegedly provided prior to Relator's beginning his employment with Ellis. (Exhibits 5, 7, 8, 10, 12, 13, 17, 18, 19). Some of the HICF sheets also contain NPI numbers for other individual providers that Relator does not recognize as employees of Ellis or Greater Southwest. (Exhibits 3, 6, 9, 11). All of the clients on the HICF sheets have identical diagnostic codes and the same provider location, which is the Grand Avenue address. None of the clients are known to Relator.

5.10. Therefore, Relator believes Defendants have billed Medicaid for services they have not provided, and have billed Medicaid for services rendered to patients they have not treated.

Further, Relator believes Defendants have used his NPI number and the NPI number of other individual practitioners to bill Medicaid for services to patients that none of these practitioners have treated at the Grand Avenue location.

VI.

DEFENDANTS' UNLAWFUL ACTS UNDER THE FALSE CLAIMS ACT

6.1. Relator alleges and incorporates the above paragraphs as if fully set forth herein.

6.2. In connection with services rendered to patients covered by the Medicaid program, Defendants have conspired to and have in fact, knowingly or intentionally, caused the Medicaid program to overcharged, through the following acts:

a. Pursuant to Section 3729(a)(1)(A), Title 31 of the United States Code, Defendants knowingly presented, or caused to be presented, a false or fraudulent claim for payment or approval;

b. Pursuant to Section 3729(a)(1)(B), Title 31 of the United States Code, Defendants knowingly made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim; and

c. Pursuant to Section 3729(a)(1)(C), Title 31 of the United States Code, Defendants conspired to commit a violation of subparagraph (A) and (B).

6.3. Each of such acts and omissions by Defendants, singularly or in combination with others, constitute a False Claim.

VII.

CAUSATION

7.1. The United States Government made excessive Medicaid payments based upon these misrepresentations and failure to disclose material facts and was therefore damaged.

7.2. The Defendants have profited and the United States Government has paid excessive Medicaid reimbursements and has suffered monetary damages by the unlawful acts of Defendants.

7.3. The United States Government, unaware of Defendants' wrongdoing and unlawful acts, paid excessive Medicaid reimbursements that otherwise would not have been allowed.

7.4. Defendants' acts and omissions constitute unlawful conduct, violations of the False Claims Act, and were a legal cause, proximate cause, and/or cause-in-fact of the Government's damages.

VIII.

DAMAGES

8.1. Relator alleges and reincorporates by reference as set forth herein the allegations contained in the above paragraphs.

8.2. Pursuant to the False Claims Act, Defendants are liable for a civil penalty of not less than $5,000 and not more than $10,000.

8.3 Pursuant to the False Claims Act, Defendants are liable for damages to the United States Government in the amount of three (3) times the amount of damages which the Government sustains because of these acts.

8.3. This action is a claim for damages as required by Section 3729, Title 31 of the United States Code.

IX.

DEMAND FOR JURY TRIAL

9.1. Relator, on behalf of himself and the United States Government, demands a jury trial on all claims alleged herein pursuant to Rule 38 of the Federal Rules of Civil Procedure.

X.

PRAYER FOR RELIEF

WHEREFORE, Relator respectfully requests as follows:

1. That Defendants be cited to appear and answer this lawsuit;

2. That the United States Government, upon trial of this cause, be awarded the following damages:

   a. monetary relief in the amount of any payment provided under the Medicaid program as a result of Defendants' unlawful acts;

   b. interest on the amount of the payment at the prejudgment interest rate in effect on the date the payment was paid, for the period from the date the benefit was paid to the date that the Government recovers the amount of the payment;

   c. a civil penalty of not less than $5,000.00 and not more than $10,000.00;

   d. three (3) times the amount of the payments made by the United States Government under the Medicaid program as a result of Defendants' unlawful acts; and

   e. post-judgment interest and reasonable attorneys' fees, costs, and expenses that the Government reasonably incurred in obtaining civil remedies or in conducting investigations in connection with this litigation; and

3. That Relator, upon trial of this cause, be awarded the following damages:

   a. the maximum percentage of the amounts recovered by the United States Government as a result of this action in accordance with Section 3730(d), Title 31 of the United States Code; and

   b. reasonable expenses, reasonable attorneys' fees, and costs that Relator necessarily incurred in bringing this action and advancing this case to litigation.

4. Plaintiffs further pray for such other and further relief as to which they are justly entitled.

Respectfully submitted,

WITT, McGREGOR & BOURLAND, P.L.L.C.

By: /s/ Matthew C. Witt
MATTHEW C. WITT

State Bar No. 21831780

8004 Woodway Drive, Suite 400
Waco, Texas 76712
(254) 751-9133
(254) 751-9134 *fax*
mattwitt@wmbwaco.com

ATTORNEYS FOR PLAINTIFF
UNITED STATES GOVERNMENT
ex rel. CLINT ANDERSON

EXHIBIT tabbies 1

CLAIMS FILING INFORMATION

Website:www.tmhp.com

Claim type form 1500

Medicaid number is also the client number

COMPANY INFORMATION

1. GREATER SOUTHWEST GROUP
   307 NORTH GRAND AVENUE
   WAXAHACHIE,TEXAS 75165
   972-291-2929
   EIN#-010866255
   NPI#1619203361

   DIAGNOSIS CODE-309.28
   PROCEDURE CODE-90806
   LOGIN-Intern75104
   Password-~~greater3071~~ South3071

2. ELLIS COUNTY COMMUNITY SERVICES
   625 JEALOUSE WAY
   SUITE 116
   CEDAR HILL,TEXAS 75104
   972-768-2908
   EIN#-272493382
   NPI#1376864363

   DIAGNOSIS CODE-309.28
   PROCEDURE CODE-90806
   LOGIN-Office75104
   PASSWORD- ~~ellis3071~~
   County 3071

EXHIBIT tabbies 2

07/22/2007 22:15 2147249977 PAGE 01/01

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

CARRIER

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)			1a. INSURED'S I.D. NUMBER (For Program in Item 1) REDACTED
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) REDACTED	3. PATIENT'S BIRTH DATE MM DD YY Redacted SEX M [X] F [ ]		4. INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED
5. PATIENT'S ADDRESS (No., Street) REDACTED	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]		7. INSURED'S ADDRESS (No., Street) REDACTED
CITY CANYON STATE TX	8. PATIENT STATUS Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [X] Part-Time Student [ ]		CITY CANYON STATE TX
ZIP CODE 79015-6405 TELEPHONE (Include Area Code) ( )			ZIP CODE 79015-6405 TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]		a. INSURED'S DATE OF BIRTH MM DD YY REDACTED SEX M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 309 28 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06 02 12 | 06 02 12	1		90847	1	160 00	2		NPI	1871621060 1376864363
2	06 03 12 | 06 03 12	1		90847	1	160 00	2		NPI	1871621060 1376864363
3	06 05 12 | 06 05 12	1		90847	1	160 00	2		NPI	1871621060 1376864363
4	06 07 12 | 06 07 12	1		90847	1	160 00	2		NPI	1871621060 1376864363
5	06 09 12 | 06 09 12	1		90847	1	160 00	2		NPI	1871621060 1376864363
6	06 10 12 | 06 10 12	1		90847	1	160 00	2		NPI	1871621060 1376864363

25. FEDERAL TAX I.D. NUMBER SSN EIN REDACTED [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 960 00	29. AMOUNT PAID $	30. BALANCE DUE $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 07 25 2012	32. SERVICE FACILITY LOCATION INFORMATION ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104	33. BILLING PROVIDER INFO & PH # ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EXHIBIT 3

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CLAIMS
PO BOX
AUSTIN TX 78720-0735

CARRIER

PICA PICA

1. MEDICARE / MEDICAID [X] / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER

1a. INSURED'S I.D. NUMBER (For Program in Item 1): REDACTED

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REDACTED

3. PATIENT'S BIRTH DATE: Redacted — SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REDACTED

5. PATIENT'S ADDRESS (No., Street): REDACTED

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): REDACTED

CITY: LONGVIEW — STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [X] Part-Time Student [ ]

CITY: LONGVIEW — STATE: TX

ZIP CODE: 75604 — TELEPHONE (Include Area Code): ( )

ZIP CODE: 75604 — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH (MM DD YY): REDACTED — SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) — SEX: M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [ ] NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 309 28
2.
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06 16 12	06 16 12	1		90847		1	160 00	2		NPI	1689948895 / 1376864363
2	06 17 12	06 17 12	1		90847		1	160 00	2		NPI	1689948895 / 1376864363
3	06 23 12	06 23 12	1		90847		1	160 00	2		NPI	1689948895 / 1376864363
4	06 24 12	06 24 12	1		90847		1	160 00	2		NPI	1689948895 / 1376864363
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: REDACTED — SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 640 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 640 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED — DATE: 08 01 2012

32. SERVICE FACILITY LOCATION INFORMATION

ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )

ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b. 216914601

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Printed on: 3/12/2012 1:00:14 PM

Patient Information

	[redacted]
	[redacted]
	M
	[redacted]
	[redacted] LONGVIEW, TX 7560[redacted]
	out-of-state
	INDIV OUTS

Inquiry Information

[redacted]	1376364363
[redacted]	3/1/2012
[redacted]	3/9/2012
Medicaid Patient No.	[redacted]
Social Security Number	
Date of Birth	[redacted]

Eligibility Segments

EFF : 2/1/2012 TRM : 3/31/2012 ADD : 12/21/2011	13 SSI, RECIPIENT	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments
No Medicare Segments found

Lock-In Segments
No Lock-In Segments found

TPR Segments
No TPR Segments found

TPL Segments
No TPL Segments found

Managed Care Segments
No Managed Care Segments found

Limits Segments

2/10/2012				4/5/2010

Jun 90847
16,17
13,24
1689948895

10002003020122095685283685 Paid

EXHIBIT 4 tabbies

TMHP

Navigation

- TexMedConnect
  - Acute Care
    - Eligibility
      - Eligibility
      - Client Group List
      - EV Batch History
    - Claims
      - Claims Entry
      - Individual Template
      - Draft
      - Pending Batch
      - Batch History
    - CSF
    - R&S
    - Appeals
    - ANSI 835
  - TexMedConnect Ready

Eligibility Verification Results

Ellis

New Lookup Return with Search Criteria

Patient Information

Client No./Trainee SSN	[redacted]
DOB	[redacted]
Gender	M
SSN	
Name	[redacted]
Address	[redacted] LONGVIEW, TX 7560[redacted]
County	Gregg
Medicare No.	
Base Plan	

Inquiry Information

NPI/API	L[redacted]
Eligibility From	2/1/2012
Eligibility Through	2/17/2012
Medicaid /Client No.	[redacted]
Social Security Number	
Date of Birth	
Last Name	
First Name	

Eligibility Segments

Segment Dates	Medical Coverage	Program Type	Program	Benefit Plan	Spend-down

Feb
4,5 7,9
11,12 14,16
18,19 21,23
25,26

1033273156
$80
90806

2000 2003 2012 2048 1003 7113

Paid
$0

EXHIBIT tabbies 5

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	PICA
	REDACTED	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
REDACTED	REDACTED M [X] F [ ]	REDACTED
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
REDACTED	Self [X] Spouse [ ] Child [ ] Other [ ]	REDACTED
CITY: WACO — STATE: TX	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]	CITY: WACO — STATE: TX
ZIP CODE: 76712 — TELEPHONE (Include Area Code): ( )	Employed [ ] Full-Time Student [X] Part-Time Student [ ]	ZIP CODE: 76712- — TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
		REDACTED M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE — DATE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 309 28 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 04 03 12	04 03 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
2 04 05 12	04 05 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
3 04 07 12	04 07 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
4 04 08 12	04 08 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
5 04 10 12	04 10 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
6 04 12 12	04 12 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363

25. FEDERAL TAX I.D. NUMBER: REDACTED SSN EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE $ 960 00	29. AMOUNT PAID $	30. BALANCE DUE $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
06 19 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM SUB-

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN#) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	CARRIER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) REDACTED	3. PATIENT'S BIRTH DATE SEX REDACTED M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED
5. PATIENT'S ADDRESS (No., Street) REDACTED	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street) REDACTED
CITY WACO STATE TX	8. PATIENT STATUS Sing'e [X] Married [ ] Other [ ]	CITY WACO STATE TX
ZIP CODE 76712 TELEPHONE (Include Area Code) ( )	Employed [ ] Full-Time Student [X] Part-Time Student [ ]	ZIP CODE 76712 TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH SEX REDACTED M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 309 28
2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 04 14 12	04 14 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363
2 04 15 12	04 15 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363
3 04 17 12	04 17 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363
4 04 19 12	04 19 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363
5 04 21 12	04 21 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363
6 04 22 12	04 22 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363

25. FEDERAL TAX I.D. NUMBER REDACTED SSN EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 960 00

29. AMOUNT PAID $

30. BALANCE DUE $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
06 19 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER: REDACTED

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REDACTED

3. PATIENT'S BIRTH DATE: REDACTED SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REDACTED

5. PATIENT'S ADDRESS (No., Street): REDACTED

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): REDACTED

CITY: WACO STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: WACO STATE: TX

ZIP CODE: 76712 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [X]

ZIP CODE: 76712- TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: REDACTED SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

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14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 309 28
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1	04	24	12	04	24	12	1		90847		1	160 00	2		1871621060
														NPI	1376864363
2	04	28	12	04	28	12	1		90847		1	160 00	2		1871621060
														NPI	1376864363
3	04	29	12	04	29	12	1		90847		1	160 00	2		1871621060
														NPI	1376864363
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: REDACTED [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 480 00

29. AMOUNT PAID $

30. BALANCE DUE $ 480 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

06 19 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

NUCC Instruction Manual Available at www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Printed on: 6/14/2012 9:05:37 PM

Patient Information

Client No./Name/SSN	[redacted]
DOB	[redacted]
Gender	M
SSN	
Name	[redacted]
Address	[redacted] WACO, TX 7671[redacted]
County	McLennan
Medicare No.	
Case Plan	INDIV OUTS

Inquiry Information

NPI/API	1376854363
Eligibility From	4/1/2012
Eligibility Through	4/30/2012
Medicaid / Client No.	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	
First Name	

28

Eligibility Segments

Segment Date	Medical Coverage	Program Type	Program	Benefit Plan	Spend-down Indicator
EFF : 5/1/2010 TRM : 6/30/2012 ADD : 4/9/2010	13 SSI, RECIPIENT	REGULAR	R	100 - TRADITIONAL MEDICAID	

LMFT

Medicare Segments

No Medicare Segments found

April
3,5
10,12
17,19
24
7,8
14,15
21,22
28,29
90847
1871621060

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

Segment Date	Organization	Name	Phone
EFF : 3/1/2012 TRM : 6/30/2012 ADD : 2/10/2012	MCNA		
EFF : 3/1/2012 TRM : 6/30/2012 ADD : 2/10/2012	MCNA		

Limits Segments

Dental	Hearing Aid	Eye Exam	Eye Glasses	Medical
10/11/2011			6/21/2011	5/18/2012

#100020030201216743617412 / Paid

PDF Generated Document.

EXHIBIT 6

HEALTH INSURANCE CLAIM FORM

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

X

REDACTED
REDACTED

MARSHALL TX

75670

REDACTED X

REDACTED
REDACTED

MARSHALL TX

75670

REDACTED X

SIGNATURE ON FILE

SIGNATURE ON FILE

309 28

04	07	12	04	07	12	1	90847		1	160 00	2	1467637181	1376864363
04	08	12	04	08	12	1	90847		1	160 00	2	1467637181	1376864363
04	14	12	04	14	12	1	90847		1	160 00	2	1467637181	1376864363
04	15	12	04	15	12	1	90847		1	160 00	2	1467637181	1376864363
04	21	12	04	21	12	1	90847		1	160 00	2	1467637181	1376864363
04	22	12	04	22	12	1	90847		1	160 00	2	1467637181	1376864363

REDACTED X X 960 00 960 00

08 01 2012

ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
1376864363

ELLIS COUNTY COMMUNITY SERVICES,INC
625 SEALOUSE WAY # 116
CEDAR HILL TX 75104
1376864363 : 216914601

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

CARRIER

PICA

1. MED DARE (Medicare #) | MEDICAID (Medicaid #) [X] | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER: REDACTED

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REDACTED

3. PATIENT'S BIRTH DATE: REDACTED SEX: M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REDACTED

5. PATIENT'S ADDRESS (No., Street): REDACTED

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street): REDACTED

CITY: MARSHALL STATE: TX

8. PATIENT STATUS: Single [X] Married Other

CITY: MARSHALL STATE: TX

ZIP CODE: 75670 TELEPHONE (Include Area Code): ( )

Employed Full-Time Student Part-Time Student [X]

ZIP CODE: 75670 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH: REDACTED SEX: M [X] F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO If yes, return to and complete item 9 a-d

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

14. DATE OF CURRENT: MM DD YY ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E By Line)

1. 309 28
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
04 28 12	04 28 12	1		90847		1	160 00	2			1467637181
										NPI	1376864363
04 29 12	04 29 12	1		90847		1	160 00	2			1467637181
										NPI	1376864363
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: REDACTED SSN EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE: $ 320 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 320 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

08 01 2012

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b.

33. BILLING PROVIDER INFO & PH #
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b. 216914601

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PATIENT AND INSURED INFORMATION

Ellis

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Printed on: 7/22/2012 12:29:18 PM

Patient Information

Client No./Trailer SSN	[redacted]
DOB	[redacted]
Gender	M
SSN	
Name	[redacted]
Address	[redacted] MARSHALL, TX 75670
County	Harrison
Medicare No.	
Base Plan	

Inquiry Information

NPI / API	1376364363
Eligibility From	4/1/2012
Eligibility Through	4/30/2012
Medicaid Client No.	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	
First Name	

Eligibility Segments

Segment Dates	Medical Coverages	Program Type	Program	Managed Care Plan	Special Circumstances
EFF : 2/1/2012 TRM : 7/31/2012 ADD : 2/23/2012	43 RIBICOFF CHILDREN UNDER AGE 4 WITH INC	REGULAR	R	100 - TRADITIONAL MEDICAID	Unknown

6

April 908.47 146763781
7 8
14 15
21 22
28 29

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

Segment Dates	Organization	Name	Phone
EFF : 4/1/2012 TRM : 7/31/2012 ADD : 2/23/2012	DELTA DENTAL		

Limits Segments

Dental	Hearing Aid	Eye Exam	Eye Glasses	Medical
4/13/2011				8/30/2011

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 7/22/2012 12:29:18 PM

Patient Information

[redacted]
M
[redacted] MARSHALL, TX 75570 [redacted]
Harrison

Inquiry Information

[redacted]	1376864353
Eligibility From	4/1/2012
Eligibility Through	4/30/2012
Medicaid/Client No	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	
First Name	

Eligibility Segments

EFF : 2/1/2012 TRM : 7/31/2012 ADD : 2/23/2012	43 RIBICOFF CHILDREN UNDER AGE 4 WITH INC	REGULAR	R	100 - TRADITIONAL MEDICAID

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments Found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

EFF : 4/1/2012 TRM : 7/31/2012 ADD : 2/23/2012	DELTA DENTAL		

Limits Segments

4/13/2011				8/30/2011

10002003020122095681 9353

EXHIBIT tabbies 7

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): REDACTED

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REDACTED

3. PATIENT'S BIRTH DATE MM DD YY: REDACTED SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REDACTED

5. PATIENT'S ADDRESS (No., Street): REDACTED

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): REDACTED

CITY: KILLEEN STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: KILLEEN STATE: TX

ZIP CODE: 76549 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: 76549 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: REDACTED SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1 309 28

2

3

4

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
03 01 12	03 01 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: REDACTED [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 160 00

29. AMOUNT PAID $

30. BALANCE DUE $ 160 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

06 01 2012

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b.

33. BILLING PROVIDER INFO & PH #

ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b. 216914601

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM 1500 (08-05)

PATIENT AND INSURED INFORMATION — CARRIER — PHYSICIAN OR SUPPLIER INFORMATION

Ellis

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 3/13/2012 9:46:52 AM

Patient Information

Recipient's Medicaid ID	[redacted]
DOB	[redacted]
Gender	M
SSN	
Name	[redacted]
Address	[redacted] KILLEEN, TX 75549
County	Bell
Medicare ID	
Case Name	INDIV OUTS

Inquiry Information

NPI / API	1619203351
Eligibility From	3/1/2012
Eligibility Through	3/9/2012
Medicaid / Patient No	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	
First Name	

Eligibility Segments

Eligibility Dates	Medicaid Coverage	Program Name	Program	Benefit Plan	Spenddown Indicator
EFF : 7/1/2010 TRM : 3/31/2012 ADD : 5/20/2010	13 SSI, RECIPIENT	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found

March
1 90847
1871421060

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

Service Dates	Description	Name	Phone
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/10/2012	MCNA		
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/10/2012	MCNA		

Limits Segments

Service	Begin	End	Limit	Remaining
7/9/2009			8/17/2010	

#10002003020121533981248 3 / Paid

EXHIBIT 8

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted	3. PATIENT'S BIRTH DATE SEX Redacted M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted
5. PATIENT'S ADDRESS (No., Street) Redacted	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street) Redacted
CITY TEMPLE STATE TX	8. PATIENT STATUS Single [X] Married [ ] Other [ ]	CITY TEMPLE STATE TX
ZIP CODE 76501 TELEPHONE (Include Area Code) ( )	Employed [ ] Full-Time Student [X] Part-Time Student [ ]	ZIP CODE 76501 TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH SEX Redacted M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH SEX M [ ] F [ ]	b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 309 28 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
03 01 12	03 01 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN Redacted [X]
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE $ 160 00
29. AMOUNT PAID $
30. BALANCE DUE $ 160 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
06 01 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

CARRIER

Ellis

TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
TMHP A STATE MEDICAID CONTRACTOR

Printed on: 3/13/2012 9:48:05 AM

Patient Information

Recipient Name / SSN	[redacted]
DOB	[redacted]
Gender	M
SSN	
Address	[redacted]
City	[redacted] TEMPLE, TX 7650[redacted]
County	Bell
Medicare No	
Medicaid No	

Inquiry Information

NPI / API	1619203361
Eligibility From Date	3/1/2012
Eligibility Through Date	3/9/2012
Medicaid / Client No	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	
First Name	

Eligibility Segments

Segment Dates	Medicaid Eligibility	Program Type	Recipient	Benefit Plan	Benefit Limitation
EFF : 12/1/2011 TRM : 3/31/2012 ADD : 1/4/2012	44 MEDICAID EXPANSION FOR CHILDREN (FEDER	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found

March
1 90847
1871421060

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

Segment Dates	Organization	Plan	Provider
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/10/2012	MCNA		
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/10/2012	MCNA		

Limits Segments

Benefit	Maximum	Balance	Eyeglasses	Medical
2/28/2012				9/15/2011

#10002003020121533981247 6 / Paid

EXHIBIT tabbies 9

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

CARRIER

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	Redacted	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Redacted	Redacted M [ ] F [X]	Redacted
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
Redacted	Self [X] Spouse [ ] Child [ ] Other [ ]	Redacted
CITY: BOERNE	STATE: TX	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
ZIP CODE: 78006	TELEPHONE (Include Area Code): ( )	Employed [ ] Full-Time Student [X] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH MM DD YY: Redacted SEX M [ ] F [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 309 28 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 02 12	06 02 12	1		90847		1	160 00	2		NPI	1689948895 / 1376864363
2 06 03 12	06 03 12	1		90847		1	160 00	2		NPI	1689948895 / 1376864363
3 06 09 12	06 09 12	1		90847		1	160 00	2		NPI	1689948895 / 1376864363
4 06 10 12	06 10 12	1		90847		1	160 00	2		NPI	1689948895 / 1376864363
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: Redacted SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 640 00	29. AMOUNT PAID $	30. BALANCE DUE $ 640 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

08 01 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM OSC 1500 08/05

Ellis

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 7/22/2012 12:52:17 PM

Patient Information

[illegible] SSN	[redacted]
[illegible]	[redacted]
[illegible]	F
[illegible]	
[illegible]	[redacted]
[illegible]	[redacted] BOERNE, TX 7800 [redacted]
[illegible]	Kendall
[illegible]	
[illegible]	

Inquiry Information

NPI/API	1376854363
~~Eligibility From~~	~~5/1/2012~~
Eligibility Through	5/30/2012
Medicaid/Client No	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	
First Name	

8

Eligibility Segments

[illegible]	[illegible]	[illegible]	[illegible]	Benefit Plan	[illegible]
EFF : 9/1/2011 TRM : 7/31/2012 ADD : 8/3/2011	21 ADOPTION SUBSIDY PROGRAM	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found

June
213 90847
9,10 1689948895

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

[illegible]	[illegible]	Name	Phone
EFF : 3/1/2012 TRM : 7/31/2012 ADD : 2/12/2012	DENTAQUEST	NICOLE C LOUGHLIN	(830) 249-9838

Limits Segments

[illegible]	[illegible]	Eye Exam	Eye Glasses	Medical
9/1/2011				4/22/2009

100020030201220956822399 / Paid

PDF Generated Document

EXHIBIT tabbies 10

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted	3. PATIENT'S BIRTH DATE SEX Redacted M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted
5. PATIENT'S ADDRESS (No., Street) Redacted	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street) Redacted
CITY LONGVIEW STATE TX	8. PATIENT STATUS Single [X] Married [ ] Other [ ]	CITY LONGVIEW STATE TX
ZIP CODE 75604 TELEPHONE (Include Area Code) ( )	Employed [ ] Full-Time Student [X] Part-Time Student [ ]	ZIP CODE 75604 TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH SEX Redacted M [ ] F [X]
b. OTHER INSURED'S DATE OF BIRTH SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 309 28 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H (EPSDT Family Plan)	I ID. QUAL.	J RENDERING PROVIDER ID. #
03 05 12	03 05 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 07 12	03 07 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 09 12	03 09 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 12 12	03 12 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 14 12	03 14 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 16 12	03 16 12	1		90847		1	160 00	2		NPI	1871621060 1376864363

25. FEDERAL TAX I.D. NUMBER SSN EIN Redacted [ ] [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE $ 960 00	29. AMOUNT PAID $	30. BALANCE DUE $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
06 07 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM 1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA — CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REDACTED	3. PATIENT'S BIRTH DATE: Redacted SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted	
5. PATIENT'S ADDRESS (No., Street): REDACTED	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): Redacted	
CITY: LONGVIEW STATE: TX	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
CITY: LONGVIEW STATE: TX	
ZIP CODE: 75604 TELEPHONE (Include Area Code): ( )	Employed [ ] Full-Time Student [X] Part-Time Student [ ]
ZIP CODE: 75604 TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]
a. INSURED'S DATE OF BIRTH MM DD YY: Redacted SEX: M [ ] F [X]	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 309 28 2. 3. 4.	22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 03 19 12	03 19 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
2 03 21 12	03 21 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
3 03 23 12	03 23 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
4 03 26 12	03 26 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
5 03 28 12	03 28 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
6 03 30 12	03 30 12	1		90847		1	160 00	2		NPI	1871621060 1376864363

25. FEDERAL TAX I.D. NUMBER: Redacted SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 960 00	29. AMOUNT PAID: $	30. BALANCE DUE: $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
06 07 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION:
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

PHYSICIAN OR SUPPLIER INFORMATION — PATIENT AND INSURED INFORMATION

TMHP

Home :: TMHP.com :: My Account

Logged in as: ellis75104 | Log Off

Print Options ::

Navigation

- TexMedConnect
  - Acute Care
    - Eligibility
      - Eligibility
      - Client Group List
      - EV Batch History
    - Claims
      - Claims Entry
      - Individual Template
      - Draft
      - Pending Batch
      - Batch History
    - CSI
    - R&S
    - Appeals
    - ANSI 835
- TexMedConnect Ready

Eligibility Verification Results

New Lookup | Return with Search Criteria

Patient Information

Client No./Trainee SS#	[redacted]
DOB	[redacted]
Gender	F
SSN	
Name	[redacted]
Address	[redacted] LONGVIEW, TX 7560[redacted]
County	Gregg
Medicare No.	
Base Plan	

Inquiry Information

NPI/API	1376864363
Eligibility From	2/1/2012
Eligibility Through	2/17/2012
Medicaid /Client No.	[redacted]
Social Security Number	
Date of Birth	
Last Name	
First Name	

Eligibility Segments

Segment Dates	Medical Coverage	Program Type	Program	Benefit Plan	Spend-down

Greater

1902036890
$80
90806

Feb
4,5 7,9
11,12 14,16
18,19 21,23
25,26

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 3/13/2012 12:10:16 PM

Patient Information

Gender	F
Name	[redacted]
Address	[redacted] LONGVIEW, TX 75604
County	Gregg

Inquiry Information

Nbr / ATP	1519203361
Eligibility From	3/1/2012
Eligibility Through	3/9/2012
Medicaid / Client Nbr	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	
First Name	

12hrs

Eligibility Segments

Segment Dates	Category of Assistance	Recipient Type	Program	Benefit Plan	Spenddown Indicator
EFF : 12/1/2011 TRM : 3/31/2012 ADD : 11/9/2011	44 MEDICAID EXPANSION FOR CHILDREN (FEDER	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

March
5, 7, 9
12, 14, 16
19, 21, 23
26, 28, 30
90847
1871621040

Managed Care Segments

Segment Dates	Organization	Name	Phone
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/10/2012	MCNA		
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/10/2012	MCNA		

Limits Segments

Dental	Hearing Aid	EPSDT Exam	EPSDT Dental	Medical
		2/9/2009	2/9/2009	11/6/2002

#1000200302012153398117 31 / paid

PDF Generated Document.

EXHIBIT 11

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	PICA
1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted	3. PATIENT'S BIRTH DATE MM DD YY: Redacted; SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted	
5. PATIENT'S ADDRESS (No., Street): Redacted	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): Redacted	
CITY: MARSHALL; STATE: TX	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [X] Part-Time Student [ ]
CITY: MARSHALL; STATE: TX	
ZIP CODE: 75672; TELEPHONE (Include Area Code): ( )	ZIP CODE: 75672; TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]
a. INSURED'S DATE OF BIRTH MM DD YY: Redacted; SEX: M [X] F [ ]	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION? MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 309 28 2. 3. 4.	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
09 03 10	09 03 10	1		90806		1	113 10	2		NPI	205568302 1427381987
09 04 10	09 04 10	1		90806		1	113 10	2		NPI	205568302 1427381987
09 05 10	09 05 10	1		90806		1	113 10	2		NPI	205568302 1427381987
09 07 10	09 07 10	1		90806		1	113 10	2		NPI	205568302 1427381987
09 09 10	09 09 10	1		90806		1	113 10	2		NPI	205568302 1427381987
09 11 10	09 11 10	1		90806		1	113 10	2		NPI	205568302 1427381987

25. FEDERAL TAX I.D. NUMBER: Redacted SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 678 60	29. AMOUNT PAID $	30. BALANCE DUE $ 678 60

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
I certify that the statements on the reverse apply to this bill and are made a part thereof.
SIGNED 10 20 2010 DATE

32. SERVICE FACILITY LOCATION INFORMATION
GREATER SOUTHWEST GROUP
625 JEALOUSE WAY #113
CEDAR HILL TX 75104
a. 1619203361 b.

33. BILLING PROVIDER INFO & PH # (972) 2912929
GREATER SOUTHWEST GROUP
625 JEALOUSE WAY #113
CEDAR HILL TX 75104
a. 1619203361 b. 207547501

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

CARRIER

PICA

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE MM DD YY: Redacted | SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Redacted

CITY: MARSHALL | STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: MARSHALL | STATE: TX

ZIP CODE: 75672 | TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: 75672 | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [X] F [ ]

9a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

9b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

9c. EMPLOYER'S NAME OR SCHOOL NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

9d. INSURANCE PLAN NAME OR PROGRAM NAME:

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 309 28
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
09 12 10	09 12 10	1		90806		1	113 10	2		NPI	205568302 1427381987
09 14 10	09 14 10	1		90806		1	113 10	2		NPI	205568302 1427381987
09 16 10	09 16 10	1		90806		1	113 10	2		NPI	205568302 1427381987
09 18 10	09 18 10	1		90806		1	113 10	2		NPI	205568302 1427381987
09 19 10	09 19 10	1		90806		1	113 10	2		NPI	205568302 1427381987
09 21 10	09 21 10	1		90806		1	113 10	2		NPI	205568302 1427381987

25. FEDERAL TAX I.D. NUMBER: Redacted SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 678 60

29. AMOUNT PAID $

30. BALANCE DUE $ 678 60

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED

DATE 10 20 2010

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625 JEALOUSE WAY #113
CEDAR HILL TX 75104

a. 1619203361 b.

33. BILLING PROVIDER INFO & PH # (972)2912929

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE MM DD YY: Redacted | SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street): Redacted

CITY: MARSHALL | STATE: TX

8. PATIENT STATUS: Single [X] Married Other

CITY: MARSHALL | STATE: TX

ZIP CODE: 75672 | TELEPHONE (Include Area Code): ( )

Employed | Full-Time Student [X] | Part-Time Student

ZIP CODE: 75672 | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY: Redacted | SEX M [X] F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO If yes, return to and complete item 9 a-d.

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12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
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09 25 10	09 25 10	1		90806		1	113 10	2		NPI	205568302 1427381987
09 26 10	09 26 10	1		90806		1	113 10	2		NPI	205568302 1427381987
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: Redacted | SSN | EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE $ 339 30

29. AMOUNT PAID $

30. BALANCE DUE $ 339 30

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED 10 20 2010 DATE

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CEDAR HILL TX 75104
a. 1619203361 b.

33. BILLING PROVIDER INFO & PH # (972) 2912929
GREATER SOUTHWEST GROUP
625 JEALOUSE WAY #113
CEDAR HILL TX 75104
a. 1619203361 b. 207547501

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PATIENT AND INSURED INFORMATION — CARRIER — PHYSICIAN OR SUPPLIER INFORMATION

TMHP

TexMedConnect
Acute Care
Eligibility
Claims

Eligibility Verification Results

New Inquiry Return with Search Criteria

Patient Information

Client ID#/Trailer SSN	[redacted]
DOB	[redacted]
Gender	M
SSN	
Name	[redacted]
Address	[redacted] MARSHALL, TX [redacted]
County	Harrison
Medicare No.	
Base Plan	

Enquiry Information

NPI/API	1619203361
Eligibility From	10/1/2010
Eligibility Through	10/6/2010
Medicaid /Client No.	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	[redacted]
First Name	[redacted]

Eligibility Segments

Segment Dates	Medical Coverage	Program Type	Program	Benefit Plan	Spend-down Indicator
EFF : 9/1/2010 TRM : 10/31/2010 ADD : 10/4/2010	44 MEDICAID EXPANSION FOR CHILDREN (FEDER	REGULAR	R	150 - TRADITIONAL MEDICAID	

TexMedConnect Ready

1000200302010288604694395

Traditional

Sept
45, 7, 13, 14, 11, 12, 16, 21, 18, 19, 23, 28, 25, 30

Robinson
142-238-1987

EXHIBIT tabbies 12

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA — CARRIER

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #) X	TRICARE CHAMPUS (Sponsor's SSN#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted		3. PATIENT'S BIRTH DATE SEX: Redacted M X F					4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted
5. PATIENT'S ADDRESS (No., Street): Redacted		6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other					7. INSURED'S ADDRESS (No., Street): Redacted
CITY: SWEETWATER	STATE: TX	8. PATIENT STATUS: Single X Married Other					CITY: SWEETWATER STATE: TX
ZIP CODE: 79556	TELEPHONE (Include Area Code): ( )	Employed Full-Time Student X Part-Time Student					ZIP CODE: 79556 TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES NO					a. INSURED'S DATE OF BIRTH SEX: Redacted M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F		b. AUTO ACCIDENT? YES NO PLACE (State)					b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES NO					c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 309 28 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
03 03 12	03 03 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 04 25	03 04 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 06 12	03 06 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 08 12	03 08 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 10 12	03 10 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 11 12	03 11 12	1		90847		1	160 00	2		NPI	1871621060 1376864363

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
Redacted	X		X YES NO	$ 960 00	$	$ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
06 05 2012	ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104	ELLIS COUNTY COMMUNITY SERVICES,INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104
SIGNED DATE	a. 1376864363 b.	a. 1376864363 b. 216914601

PHYSICIAN OR SUPPLIER INFORMATION — PATIENT AND INSURED INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

1500 Case 3:15-cv-02085-L Document 1 Filed 06/19/15 Page 40 of 69 PageID 40

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

1 MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a INSURED'S I.D. NUMBER (For Program in item 1): Redacted

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3 PATIENT'S BIRTH DATE: Redacted SEX: M [X] F [ ]

4 INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5 PATIENT'S ADDRESS (No., Street): Redacted

6 PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7 INSURED'S ADDRESS (No., Street): Redacted

CITY: SWEETWATER STATE: TX

8 PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: SWEETWATER STATE: TX

ZIP CODE: 79556 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: 79556 TELEPHONE (Include Area Code): ( )

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10 IS PATIENT'S CONDITION RELATED TO:

11 INSURED'S POLICY GROUP OR FECA NUMBER:

a OTHER INSURED'S POLICY OR GROUP NUMBER:

a EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a INSURED'S DATE OF BIRTH MM DD YY: Redacted SEX: M [X] F [ ]

b OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b EMPLOYER'S NAME OR SCHOOL NAME:

c EMPLOYER'S NAME OR SCHOOL NAME:

c OTHER ACCIDENT? YES [ ] NO [ ]

c INSURANCE PLAN NAME OR PROGRAM NAME:

d INSURANCE PLAN NAME OR PROGRAM NAME:

10d RESERVED FOR LOCAL USE:

d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14 DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19 RESERVED FOR LOCAL USE

20 OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1 309 28 3 2 4

22 MEDICAID RESUBMISSION CODE ORIGINAL REF. NO

23 PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
03 13 12	03 13 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 15 12	03 15 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 17 12	03 17 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 18 12	03 18 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 20 12	03 20 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 22 12	03 22 12	1		90847		1	160 00	2		NPI	1871621060 1376864363

25 FEDERAL TAX I.D. NUMBER: Redacted SSN [ ] EIN [X]

26 PATIENT'S ACCOUNT NO.:

27 ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28 TOTAL CHARGE: $ 960 00

29 AMOUNT PAID: $

30 BALANCE DUE: $ 960 00

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

06 05 2012

SIGNED DATE

32 SERVICE FACILITY LOCATION INFORMATION:
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a 1376864363 b

33 BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a 1376864363 b 216914601

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE MM DD YY: Redacted | SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Redacted

CITY: SWEETWATER | STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: SWEETWATER | STATE: TX

ZIP CODE: 79556 | TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [X]

ZIP CODE: 79556 | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: Redacted | SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE | DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 309 28
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
03 27 12	03 27 12	1		90847		1	160 00	2			NPI	1871621060
												NPI	1376864363
03 29 12	03 29 12	1		90847		1	160 00	2			NPI	1871621060
												NPI	1376864363
03 31 12	03 31 12	1		90847		1	160 00	2			NPI	1871621060
												NPI	1376864363
												NPI	
												NPI	
												NPI	

25. FEDERAL TAX I.D. NUMBER: Redacted | SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 480 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 480 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

06 05 2012

SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b. 216914601

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 3/13/2012 12:15:49 PM

Patient Information

Client No. / Trunked SSN	[redacted]
DOB	[redacted]
Gender	M
SSN	
Name	[redacted]
Address	[redacted] SWEETWATER, TX 79555
County	Nolan
Medicare No.	
Case Type	INDIV OUTS

Inquiry Information

NPI/API	1619203361
Eligibility From	3/1/2012
Eligibility Through	3/9/2012
Medicaid / Client No.	[redacted]
Social Security Number	
Date Of Birth	[redacted]
Last Name	
First Name	

30hr

Eligibility Segments

Segment Dates	Medicaid Eligibility	Program Type	Program	Benefit Plan	Service Delivery Area
EFF : 9/1/2011 TRM : 3/31/2012 ADD : 7/26/2011	13 SSI, RECIPIENT	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

March
6, 8 3, 4 90847
13, 15 10, 11
20, 22 17, 18
27, 29 31 1871691060

Managed Care Segments

Segment Dates	Organization	Name	Phone
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/15/2012	DENTAQUEST	[redacted]	[redacted]
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/15/2012	DENTAQUEST	[redacted]	[redacted]

Limits Segments

Dental	Hearing Aid	Eye Exam	Eye Glasses	Medical	C
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	

10002003020121534062706 2 / paid

EXHIBIT 13

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08 05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE SEX: Redacted [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street): Redacted

CITY: TEMPLE | STATE: TX

8. PATIENT STATUS: Single [X] Married Other

CITY: TEMPLE | STATE: TX

ZIP CODE: 76501 | TELEPHONE (Include Area Code): ( )

Employed | Full-Time Student | Part-Time Student [X]

ZIP CODE: 76501- | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY: Redacted SEX M [X] F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 309 28
2.
3.
4.

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23. PRIOR AUTHORIZATION NUMBER

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03 05 12	03 05 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 07 12	03 07 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 09 12	03 09 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 12 12	03 12 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 14 12	03 14 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 16 12	03 16 12	1		90847		1	160 00	2		NPI	1871621060 1376864363

25. FEDERAL TAX I.D. NUMBER: Redacted SSN EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE: $ 960 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

06 05 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b.

33. BILLING PROVIDER INFO & PH #
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b. 216914601

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] TRICARE CHAMPUS (Sponsor's SSN#) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]	1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted	3. PATIENT'S BIRTH DATE: Redacted SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted	
5. PATIENT'S ADDRESS (No., Street): Redacted	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): Redacted	
CITY: TEMPLE STATE: TX	8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [X]
CITY: TEMPLE STATE: TX	
ZIP CODE: 76501- TELEPHONE (Include Area Code): ( )	ZIP CODE: 76501- TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]
a. INSURED'S DATE OF BIRTH MM DD YY: Redacted SEX M [X] F [ ]	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 309 28 2. 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
03 19 12	03 19 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 21 12	03 21 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 23 12	03 23 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 26 12	03 26 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 28 12	03 28 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
03 30 12	03 30 12	1		90847		1	160 00	2		NPI	1871621060 1376864363

25. FEDERAL TAX I.D. NUMBER: Redacted SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 960 00	29. AMOUNT PAID $	30. BALANCE DUE $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
06 05 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH #
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

E 1115

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 3/13/2012 12:36:29 PM

Patient Information

Last, First Name, SS	[redacted]
DOB	[redacted]
Gender	M
SSN	[redacted]
Address	[redacted] TEMPLE, TX 76501
County	Bell
Medicaid Client No	[redacted]

Inquiry Information

KPI/APP	1619203361
Eligibility From	3/1/2012
Eligibility Through	3/9/2012
Medicaid Client No	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	
First Name	

12hrs

Eligibility Segments

EFF : 10/1/2011 TRM : 3/31/2012 ADD : 8/23/2011	01 TANF, CASH GRANT	REGULAR		R	100 - TRADITIONAL MEDICAID

Medicare Segments

No Medicare Segments found

March
5, 7, 9
12, 14, 16
19, 21, 23
26, 28, 30

90847
1871621060

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/10/2012	MCNA
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/10/2012	MCNA

Limits Segments

3/7/2011 — 9/14/2011

#10002003020121533980 2781 / Paid

EXHIBIT tabbies 14

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

CARRIER

MED CARE (Medicare #)	MED CAID (Medicaid #) X	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	PICA	
							Redacted		

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	PATIENT AND INSURED INFORMATION
Redacted	Redacted M X F	Redacted	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
Redacted	Self X Spouse Child Other	Redacted	
CITY	STATE	8. PATIENT STATUS	CITY	STATE
BROWNWOOD	TX	Single X Married Other	BROWNWOOD	TX
ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)
76801	( )	Employed Full-Time Student X Part-Time Student	76801	( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX	
		Redacted M X F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX	b. AUTO ACCIDENT? PLACE (State) YES NO	b. EMPLOYER'S NAME OR SCHOOL NAME	
M F			
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.	

12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY / FROM / TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY / FROM / TO	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO / $ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 309 28		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
		23. PRIOR AUTHORIZATION NUMBER	

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
05 01 12	05 01 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
05 03 12	05 03 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
05 05 12	05 05 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
05 06 12	05 06 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
05 08 12	05 08 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
05 10 12	05 10 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
Redacted	X		X YES NO	$ 960 00	$	$ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
06 25 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

MED CARE (Medicare #)	MEDICAID (Medicaid #) X	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER			PICA
							Redacted			

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Redacted	Redacted M X F	Redacted
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
Redacted	Self X Spouse Child Other	Redacted
CITY: BROWNWOOD	STATE: TX	8. PATIENT STATUS: Single X Married Other
ZIP CODE: 76801	TELEPHONE (Include Area Code): ( )	Employed Full-Time Student Part-Time Student X

CITY	STATE
BROWNWOOD	TX
ZIP CODE	TELEPHONE (Include Area Code)
76801	( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
		Redacted M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX	b. AUTO ACCIDENT? PLACE (State) YES NO	b. EMPLOYER'S NAME OR SCHOOL NAME
M F		
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line) 1. 309 28 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. Qual.	J RENDERING PROVIDER ID. #
1 05 12 12	05 12 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
2 05 13 12	05 13 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
3 05 15 12	05 15 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
4 05 17 12	05 17 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
5 05 19 12	05 19 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
6 05 20 12	05 20 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
Redacted	X		X YES NO	$ 960 00	$	$ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: 06 25 2012 DATE:

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

CARRIER

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Redacted

CITY: BROWNWOOD STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: BROWNWOOD STATE: TX

ZIP CODE: 76801 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: 76801 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH: Redacted SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line)

1. 309 28

2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
05 22 12	05 22 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
05 26 12	05 26 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
05 27 12	05 27 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: Redacted SSN EIN [ ] [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 480 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 480 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

06 25 2012

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )

ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b. 216914601

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

NUCC Instruction Manual available at: www.nucc.org

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 6/17/2012 4:23:36 PM

Patient Information

Client ID / Trailer / SSN	[redacted]
DOB	[redacted]
Gender	M
SSN	
Name	[redacted]
Address	[redacted] BROWNWOOD, TX 7630[redacted]
County	Brown
Medicare No	
Plan Name	

Inquiry Information

NPI / Apt	1619203351
Eligibility From	5/1/2012
Eligibility Through	5/31/2012
Medicaid / Client No.	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	
First Name	

Eligibility Segments

30

Segment Dates	Medical Coverage	Program Type	Dual Flag	Benefit Plan	Spend Down Indicator
EFF : 12/1/2011 TRM : 6/30/2012 ADD : 12/7/2011	21 ADOPTION SUBSIDY PROGRAM	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

Mail

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27

1871621060

TPR Segments

Segment Dates	Name	Address	Phone	Additional Information
EFF : 1/25/2012 TRM : 12/31/3999	[redacted]	[redacted]		Insurance Company: [redacted] Insured's ID No. / SSN: [redacted] Relation: [redacted] Employer: Group [redacted] Coverage Code [redacted]

TPL Segments

No TPL Segments found

Managed Care Segments

Segment Dates	Organization	Name	Phone
EFF : 3/1/2012 TRM : 6/30/2012 ADD : 2/10/2012	MCNA		
EFF : 3/1/2012 TRM : 6/30/2012 ADD : 2/10/2012	MCNA		

Limits Segments

Dates	Procedure	Limits	Eyeglasses	Visual
11/17/2009				11/5/2008

1000200302012173459930258

EXHIBIT 15

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

CARRIER

PICA | PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M [ ] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Redacted

CITY: ABILENE STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: ABILENE STATE: TX

ZIP CODE: 79605 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: 79605 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH: Redacted SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 309 28
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H I J RENDERING PROVIDER ID. #
1	05 01 12	05 01 12	1		90847		1	160 00	2	1871621060 NPI 1376864363
2	05 03 12	05 03 12	1		90847		1	160 00	2	1871621060 NPI 1376864363
3	05 05 12	05 05 12	1		90847		1	160 00	2	1871621060 NPI 1376864363
4	05 06 12	05 06 12	1		90847		1	160 00	2	1871621060 NPI 1376864363
5	05 08 12	05 08 12	1		90847		1	160 00	2	1871621060 NPI 1376864363
6	05 10 12	05 10 12	1		90847		1	160 00	2	1871621060 NPI 1376864363

25. FEDERAL TAX I.D. NUMBER: Redacted SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 960 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

06 25 2012

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b. 216914601

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Redacted
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Redacted	Redacted M [ ] F [X]	Redacted
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
Redacted	Self [X] Spouse [ ] Child [ ] Other [ ]	Redacted
CITY: ABILENE	STATE: TX	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
CITY: ABILENE	STATE: TX
ZIP CODE: 79605	TELEPHONE (Include Area Code): ( )	Employed [ ] Full-Time Student [X] Part-Time Student [ ]
ZIP CODE: 79605	TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: Redacted M [ ] F [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI [ ]	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line) 1. 309 28 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 05 12 12	05 12 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
2 05 13 12	05 13 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
3 05 15 12	05 15 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
4 05 17 12	05 17 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
5 05 19 12	05 19 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
6 05 20 12	05 20 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363

25. FEDERAL TAX I.D. NUMBER: Redacted SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 960 00	29. AMOUNT PAID $	30. BALANCE DUE $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

06 25 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER: Redacted

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M [ ] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Redacted

CITY: ABILENE STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [X] Part-Time Student [ ]

CITY: ABILENE STATE: TX

ZIP CODE: 79605 TELEPHONE (Include Area Code): ( )

ZIP CODE: 79605 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH: Redacted SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH SEX: M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 309 28
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 05 22 12	05 22 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
2 05 26 12	05 26 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
3 05 27 12	05 27 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: Redacted SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 480 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 480 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

06 25 2012

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b. 216914601

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

Printed on: 6/17/2012 5:11:59 PM

Patient Information

Client No. / Patient SSN	[redacted]
DOB	[redacted]
Gender	F
Name	[redacted]
Address	[redacted] ABILENE, TX 79605
County	Taylor
Medicare No.	
Phone No.	

Inquiry Information

NPI / API	1619203361
Eligibility From	3/1/2012
Eligibility Through	3/31/2012
Medicaid Client No.	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	
First Name	

30

Eligibility Segments

Eligibility Dates	Medicaid Coverage	Program Type	Program	Benefit Plan	Spend Down Indicator
EFF : 3/1/2012 TRM : 6/30/2012 ADD : 4/2/2012	48 RIBICOFF CHILDREN UNDER AGE 4 WITH INC	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

No Managed Care Segments found

Limits Segments

Dental	Hearing AID	Eye Exam	Eye Glasses	Medical
1/15/2011				3/4/2010

May 1,3 5,10 9084?
5,6 15,17
12,13 22
19,20
26,27
1871621062

10002003020121734593530 3 / Paid

EXHIBIT tabbies 16

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE CLAIMS PO BOX AUSTIN TX 78720-0735

CARRIER

PICA

1. MED CARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted	3. PATIENT'S BIRTH DATE SEX Redacted [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted
5. PATIENT'S ADDRESS (No. Street) Redacted	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No. Street) Redacted
CITY KEMAH STATE TX	8. PATIENT STATUS Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [X] Part-Time Student [ ]	CITY KEMAH STATE TX
ZIP CODE 77565 TELEPHONE (Include Area Code) ( )		ZIP CODE 77565 TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO	a. INSURED'S DATE OF BIRTH MM DD YY Redacted SEX M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a [ ] 17b NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1 309 28 2 [ ] 3 [ ] 4 [ ]		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 05 29 12	05 29 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
2 05 31 12	05 31 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN Redacted [ ] [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE $ 320 00	29. AMOUNT PAID $	30. BALANCE DUE $ 320 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
06 25 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES, INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 2169146O1

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

NUCC Instruction Manual available at: www.nucc.org

TMHP
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 6/17/2012 5:46:15 PM

Patient Information

[redacted]	
[redacted]	
[redacted]	M
[redacted]	
[redacted]	[redacted] KEMAH, TX 7756[redacted]
[redacted]	Galveston
[redacted]	
[redacted]	INDIV OUTS

Inquiry Information

[redacted]	1619203351
[redacted]	5/8/2012
[redacted]	5/31/2012
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	
[redacted]	

4

Eligibility Segments

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EFF : 1/1/2011 TRM : 6/30/2012 ADD : 11/20/2010	13 SSI, RECIPIENT	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found

Mar
29,31 90847
187162106O

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

[redacted]	[redacted]	[redacted]	[redacted]
EFF : 3/1/2012 TRM : 6/30/2012 ADD : 1/25/2012	DELTA DENTAL		
EFF : 3/1/2012 TRM : 6/30/2012 ADD : 1/25/2012	DELTA DENTAL		

Limits Segments

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
7/24/2009				11/9/2011

10002003020121734593345 8 Paid

EXHIBIT tabbies 17

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

CARRIER

1. MEDICARE (Medicare #) [ ] MED CHID (Medicaid #) [X] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE MM DD YY: Redacted SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Redacted

CITY: BAYTOWN STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: BAYTOWN STATE: TX

ZIP CODE: 77523 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [X]

ZIP CODE: 77523- TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

e. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1 309 28

2

3

4

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
04 02 12	04 02 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363
04 04 12	04 04 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363
04 06 12	04 06 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363
04 09 12	04 09 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363
04 11 12	04 11 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363
04 13 12	04 13 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363

25. FEDERAL TAX I.D. NUMBER: Redacted SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 960 00

29. AMOUNT PAID $

30. BALANCE DUE $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

07 10 2012

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b. 216914601

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

NUCC Instruction Manual available at: www.nucc.org

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA — CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted	3. PATIENT'S BIRTH DATE: Redacted SEX: M [X] F [ ]
5. PATIENT'S ADDRESS (No., Street): Redacted	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: BAYTOWN STATE: TX	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
ZIP CODE: 77523- TELEPHONE (Include Area Code): ( )	Employed [ ] Full-Time Student [ ] Part-Time Student [X]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):
c. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? YES [ ] NO [ ]
d. INSURANCE PLAN NAME OR PROGRAM NAME:	10d. RESERVED FOR LOCAL USE:

PATIENT AND INSURED INFORMATION

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted	
7. INSURED'S ADDRESS (No., Street): Redacted	
CITY: BAYTOWN STATE: TX	
ZIP CODE: 77523 TELEPHONE (Include Area Code): ( )	
11. INSURED'S POLICY GROUP OR FECA NUMBER:	
a. INSURED'S DATE OF BIRTH MM DD YY: Redacted SEX M [X] F [ ]	
b. EMPLOYER'S NAME OR SCHOOL NAME:	
c. INSURANCE PLAN NAME OR PROGRAM NAME:	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.	

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY:

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a: 17b. NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 309 28 3. 2. 4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
04 16 12	04 16 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
04 18 12	04 18 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
04 20 12	04 20 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
04 23 12	04 23 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
04 25 12	04 25 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
04 27 12	04 27 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363

25. FEDERAL TAX I.D. NUMBER: Redacted SSN [ ] EIN [X]
26. PATIENT'S ACCOUNT NO:
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 960 00
29. AMOUNT PAID: $
30. BALANCE DUE: $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
07 10 2012
SIGNED DATE

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a. 1376864363 b.

33. BILLING PROVIDER INFO & PH #: ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
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CEDAR HILL TX 75104
a. 1376864363 b. 216914601

PHYSICIAN OR SUPPLIER INFORMATION

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1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE CLAIMS
PO BOX
AUSTIN TX 78720-0735

1. MED CARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] TRICARE CHAMPUS (Sponsor's SSN#) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER: Redacted

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Redacted

CITY: BAYTOWN STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: BAYTOWN STATE: TX

ZIP CODE: 77523 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: 77523 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: Redacted SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 309 28

2.

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
04 26 12	04 26 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
04 30 12	04 30 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: Redacted SSN EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 320 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 320 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

07 10 2012

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION:
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b.

33. BILLING PROVIDER INFO & PH #: ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b. 216914601

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

CARRIER

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 6/24/2012 1:19:42 PM

Patient Information

[redacted]	
[redacted]	
[redacted]	M
[redacted]	
[redacted]	[redacted] BAYTOWN, TX 7752[redacted]
[redacted]	Chambers

Inquiry Information

[redacted]	1519203351
[redacted]	4/1/2012
[redacted]	4/30/2012
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	

30

Eligibility Segments

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EFF : 3/1/2012 TRM : 6/30/2012 ADD : 4/5/2012	48 RIBICOFF CHILDREN UNDER AGE 4 WITH INC	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

No Managed Care Segments found

Limits Segments

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
				11/4/2011

HP: 1
2,4,6 90847
9,11,13
16,18,20
23,25,27
30, 26
1871621060

#-10002003020121814779888 1 paid

EXHIBIT tabbies 18

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

MEDICARE (Medicare #)	MEDICAID (Medicaid #) X	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	PICA

1a. INSURED'S I.D. NUMBER: Redacted	(For Program in Item 1)	PICA
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted	3. PATIENT'S BIRTH DATE: Redacted SEX: F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted
5. PATIENT'S ADDRESS (No., Street): Redacted	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street): Redacted
CITY: FREDERICKSBURG STATE: TX	8. PATIENT STATUS: Single X Married Other; Employed Full-Time Student Part-Time Student X	CITY: FREDERICKSBURG STATE: TX
ZIP CODE: 78624 TELEPHONE (Include Area Code): ( )		ZIP CODE: 78624 TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY: Redacted SEX: M F X
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M F	b. AUTO ACCIDENT? YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a 17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 309 28
2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 03 02 12	03 02 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
2 03 05 12	03 05 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
3 03 07 12	03 07 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
4 03 09 12	03 09 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
5 03 12 12	03 12 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363
6 03 14 12	03 14 12	1		90847		1	160 00	2			1871621060
										NPI	1376864363

25. FEDERAL TAX I.D. NUMBER: Redacted SSN EIN X	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE: $ 960 00	29. AMOUNT PAID: $	30. BALANCE DUE: $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
06 04 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
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PICA — CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No. Street): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No. Street): Redacted

CITY: FREDERICKSBURG STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [X] Part-Time Student [ ]

CITY: FREDERICKSBURG STATE: TX

ZIP CODE: 78624 TELEPHONE (Include Area Code): ( )

ZIP CODE: 78624 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: Redacted SEX: M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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17b NPI

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2.
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23. PRIOR AUTHORIZATION NUMBER

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2 03 19 12	03 19 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
3 03 21 12	03 21 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
4 03 23 12	03 23 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
5 03 26 12	03 26 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363
6 03 28 12	03 28 12	1		90847		1	160 00	2		NPI	1871621060 / 1376864363

25. FEDERAL TAX I.D. NUMBER: Redacted SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 960 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 960 00

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] TRICARE CHAMPUS (Sponsor's SSN#) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER: Redacted

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Redacted

CITY: FREDERICKSBURG STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: FREDERICKSBURG STATE: TX

ZIP CODE: 78624 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: 78624 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: Redacted SEX: M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 309 28 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 03 30 12	03 30 12	1		90847		1	160 00	2		NPI	1871621060
2										NPI	1376864363
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: Redacted SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 160 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 160 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

06 04 2012

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

a. 1376864363 b. 216914601

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

Ellis

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Printed on: 3/12/2012 3:43:25 PM

Patient Information

[illegible]	[redacted]
DOB	[redacted]
Gender	F
SSN	
Name	[redacted]
Address	[redacted] FREDERICKSBURG, TX 78624[redacted]
County	Gillespie
Medicare No.	
[illegible]	INDIV OUTS

Inquiry Information

NPI/API	1376864363
Eligibility From	3/1/2012
Eligibility Through	3/9/2012
Medicaid / Client No.	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	
First Name	

30

Eligibility Segments

[illegible]	Federal Status	Program Type	Program	Benefit Plan	[illegible]
EFF : 9/1/2011 TRM : 3/31/2012 ADD : 8/22/2011	13 SSI, RECIPIENT	REGULAR	R	100 - TRADITIONAL MEDICAID	

March
5, 7, 9
12, 14, 16
19, 21, 23
26, 28, 30

code
90847
1871621060

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

Segment Date	Name	Address	Phone	Additional Information
EFF : 9/1/2010 TRM : 12/31/3999	[redacted]	[redacted]	[redacted]	Insurance Company: [redacted] Insured's ID No. / SSN: [redacted] Relation: [redacted] Employer: [redacted] Group: [redacted] Coverage Code: [redacted]

TPL Segments

No TPL Segments found

Managed Care Segments

Segment Date	Organization	Name	Phone
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/14/2012	DENTAQUEST		
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/14/2012	DENTAQUEST		

Limits Segments

[illegible]	[illegible]	Eye Exam	Eye Glasses	Medical
3/30/2011			11/22/2011	3/30/2010

10002003020121534002?652

EXHIBIT tabbies 19

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted	3. PATIENT'S BIRTH DATE: Redacted SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted	
5. PATIENT'S ADDRESS (No., Street): Redacted	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): Redacted	
CITY: TEMPLE STATE: TX	8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [X] Part-Time Student [ ]
CITY: TEMPLE STATE: TX	
ZIP CODE: 76501 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 76501 TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]
a. INSURED'S DATE OF BIRTH MM DD YY: Redacted SEX: M [ ] F [X]	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):
b. EMPLOYER'S NAME OR SCHOOL NAME:	
c. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? YES [ ] NO [ ]
c. INSURANCE PLAN NAME OR PROGRAM NAME:	
d. INSURANCE PLAN NAME OR PROGRAM NAME:	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a [ ] 17b NPI [ ]
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1 309 28 2 [ ] 3 [ ] 4 [ ]	22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:
	23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 04 02 12	04 02 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
2 04 04 12	04 04 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
3 04 06 12	04 06 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
4 04 09 12	04 09 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
5 04 11 12	04 11 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
6 04 13 12	04 13 12	1		90847		1	160 00	2		NPI	1871621060 1376864363

25. FEDERAL TAX I.D. NUMBER: Redacted SSN EIN [ ] [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 960 00	29. AMOUNT PAID $	30. BALANCE DUE $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

06 29 2012

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted	3. PATIENT'S BIRTH DATE SEX Redacted M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted
5. PATIENT'S ADDRESS (No., Street) Redacted	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street) Redacted
CITY TEMPLE STATE TX	8. PATIENT STATUS Single [X] Married [ ] Other [ ]	CITY TEMPLE STATE TX
ZIP CODE 76501- TELEPHONE (Include Area Code) ( )	Employed [ ] Full-Time Student [X] Part-Time Student [ ]	ZIP CODE 76501 TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH SEX Redacted M [ ] F [X]
b. OTHER INSURED'S DATE OF BIRTH SEX M [ ] F [ ]	b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
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13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI [ ]	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 309 28 2. [ ] 3. [ ] 4. [ ]		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 04 16 12	04 16 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
2 04 18 12	04 18 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
3 04 20 12	04 20 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
4 04 23 12	04 23 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
5 04 25 12	04 25 12	1		90847		1	160 00	2		NPI	1871621060 1376864363
6 04 27 12	04 27 12	1		90847		1	160 00	2		NPI	1871621060 1376864363

25. FEDERAL TAX I.D. NUMBER Redacted	SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 960 00	29. AMOUNT PAID $	30. BALANCE DUE $ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
07 09 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Redacted

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE MM DD YY: Redacted SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Redacted

CITY: TEMPLE STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: TEMPLE STATE: TX

ZIP CODE: 76501 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: 76501 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: Redacted SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any med cal or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of med cal benefits to the undersigned physician or supplier for services described below.

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 309 28
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 04 26 12	04 26 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363
2 04 30 12	04 30 12	1		90847		1	160 00	2		NPI	1871621060
										NPI	1376864363
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: Redacted [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 320 00

29. AMOUNT PAID $

30. BALANCE DUE $ 320 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

07 09 2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b.

33. BILLING PROVIDER INFO & PH # ( )
ELLIS COUNTY COMMUNITY SERVICES,INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104
a. 1376864363 b. 216914601

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 6/23/2012 5:22:44 PM

Patient Information

[illegible] SSN	[redacted]
DOB	[redacted]
Gender	F
SSN	
Name	[redacted]
Address	[redacted] TEMPLE, TX 75501 [redacted]
County	Bell
Medicare No.	
[illegible] Plan	

Inquiry Information

NPI/API	1619203361
Eligibility From	4/1/2012
Eligibility Through	4/30/2012
Medicaid / Client No.	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	
First Name	

30

Eligibility Segments

[illegible]	[illegible]	Program Type	Program	Benefit Plan	Spend-down Indicator
EFF : 3/1/2012 TRM : 6/30/2012 ADD : 3/30/2012	48 RIBICOFF CHILDREN UNDER AGE 4 WITH INC	REGULAR	R	100 - TRADITIONAL MEDICAID	

April
2, 4, 6
9, 11, 13
16, 18, 20
23, 25, 27
30, 26
90847
1871621060

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

No Managed Care Segments found

Limits Segments

[illegible]	[illegible]	Eye Exam	Eye Glasses	Medical
				9/22/2009

1000200302012181477669903 / paid

ORIGINAL SEALED

JS 44 (Rev. 09/11)

CIVIL COVER SHEET

3-15 CV-2085-L

The JS 44 civil coversheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

RECEIVED
RAN
JUN 19 2015
CLERK U.S. DISTRICT COURT
NORTHERN DISTRICT OF TEXAS

I. (a) PLAINTIFFS

PARTIES UNDER SEAL

(b) County of Residence of First Listed Plaintiff *(EXCEPT IN U.S. PLAINTIFF CASES)*

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

WITT, McGREGOR & BOURLAND, P.L.L.C., 8004 Woodway Dr., #400, Waco, TX 76712

DEFENDANTS

PARTIES UNDER SEAL

County of Residence of First Listed Defendant ELLIS *(IN U.S. PLAINTIFF CASES ONLY)*

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☒ 1 U.S. Government Plaintiff
- ☐ 2 U.S. Government Defendant
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excl. Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Med. Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS
- ☐ 510 Motions to Vacate Sentence

Habeas Corpus:
- ☐ 530 General
- ☐ 535 Death Penalty
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Mgmt. Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Empl. Ret. Inc. Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 463 Habeas Corpus - Alien Detainee (Prisoner Petition)
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☒ 375 False Claims Act
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from another district *(specify)* ☐ 6 Multidistrict Litigation

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
31 U.S. Code Section 3730(b)

Brief description of cause:
An original source of information brings suit against a medical provider under the False Claims Act.

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A CLASS ACTION UNDER F.R.C.P. 23

DEMAND $ 3 Million Dollars

CHECK YES only if demanded in complaint:
JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) PENDING OR CLOSED:

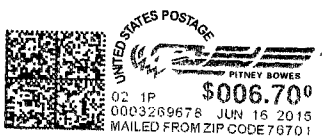
(See instructions): JUDGE Jane J. Boyle DOCKET NUMBER 3:15-CR-66-B(01)

DATE
06/16/2015

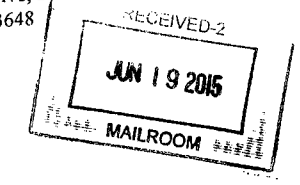
SIGNATURE OF ATTORNEY OF RECORD

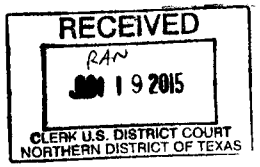
FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____



Matthew C. Witt
Witt, McGregor & Bourland, P.L.L.C.
8004 Woodway Drive, Suite 400
Waco, TX 76712-3648





U.S. District Clerk
1100 Commerce Street, Room 1452
Dallas, TX 75242